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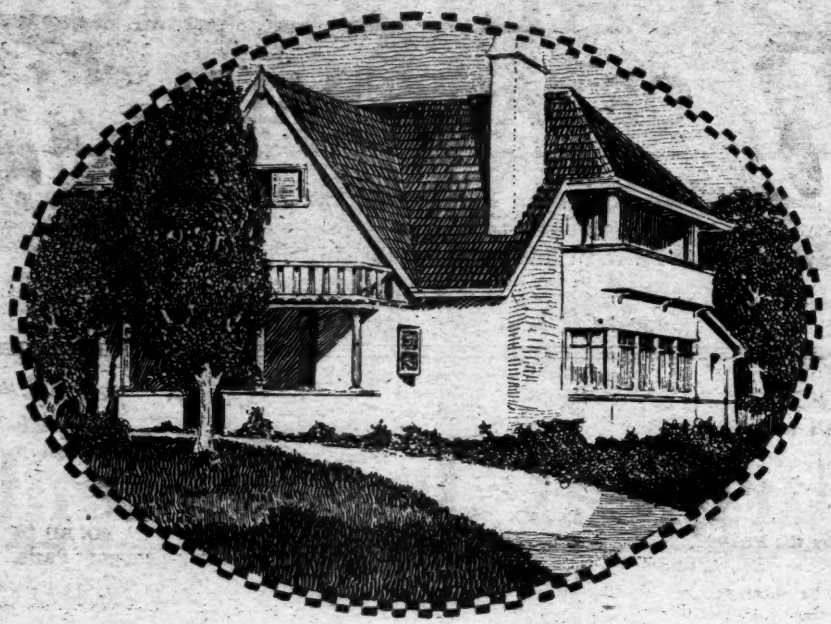

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—7TH YEAR. SYDNEY: SATURDAY, DECEMBER 25, 1920. No. 26.

THE APPLICATION OF THE LESSONS OF THE WAR TO CIVIL LIFE.[1]

By G. W. Barber, C.B., C.M.G., D.S.O., V.D., M.R.C.S. (Eng.), L.R.C.P. (Lond.),
Perth.

During the late war we applied the lessons learnt in civil life to the prevention and treatment of disease and injury, but owing to the fact that the majority of the medical profession, in common with the rest of the population of the British Empire, had failed to train for war during peace, the application in many cases failed, failure being due to ignorance of the method of obtaining action. In the later stages these methods had been learnt and I think I may say that the machine was nearly perfect, especially in the field.

It now remains for us to apply the experience gained in the war to civil life, especially as regards administration and organization. It is impossible within the compass of this paper to deal with all the lessons learnt, but I will mention some of the most important under the headings of:

(1) Prevention of disease.
(2) Treatment of disease and injury.
(3) Transport.
(4) Supply of equipment.

(1) Prevention of Disease.

As regards the first, you will at once think of that most important, but little known, unit, the sanitary section. Unfortunately, only a limited number of Australian Army Medical Corps officers are acquainted with the rôle and proper use of these units in the field. Briefly, the officer commanding acted as a medical officer of health of his area. In addition to the duties of inspection, advising and reporting, the units instructed the troops in the construction of sanitary requisites from materials readily available in the field. When the Fourth Division was torn from its prospective Christmas dinner on the coast and hurried up to the Cambrai sector, they found a most excellent sanitary museum at Peronne instituted by a British sanitary section. It consisted of models and diagrams of all requisites for the disposal and destruction of fæces, urine and rubbish, bath-houses, "delousers," disinfectors, protection from dust and flies, protection of water, etc.. I remember Major-General Sir T. Glasgow, then one of the Brigadiers, remarking that such a museum established in each Australian capital city would be of the utmost use from an educational and sanitary point of view to the inhabitants of country and mining areas. A complete set of models and diagrams was made by the Fourth Australian Sanitary Section and in the retreat of 1918 this set was rescued from the Meteren dump by Colonel Butler and subsequently forwarded to Melbourne. A claim has been made for these models on behalf of Western Australia.

I was Medical Officer of Health of the Kalgoorlie and Boulder district in the days of the typhoid epidemics. Had we had the services of a sanitary section and triple vaccine, I am sure that a large number of young lives, lost from preventible disease, would have been saved and the Government spared the great expense involved in the long treatment necessary. A mobile, well-trained sanitary section operating in this vast country would, I think, prove a good financial proposition. Each army was provided with mobile hygienic and pathological laboratories; consequently, all necessary examinations could be made in the field. Such units should be of great value in this country, perhaps not motor driven, but adapted to the railway system. Similarly, "Foden" lorry Thresh disinfectors, always so urgently required by brigadiers when coming out of the line, could be adapted to the railway system and be moved rapidly to the nearest point required. Rapidity is essential in dealing with disease and this is often lacking in civil life.

The posting of dental units to the Australian Corps resulted in a complete absence of evacuations for dental troubles. Such mobile units would prove of great value in dealing with the prevention of dental caries in children in country districts.

(2) Treatment of Disease and Injury.

The treatment of disease in the latter stages of the war is generally considered to have been highly successful. The same cannot be said of the early stages, owing to the lack of good organization and administration. Returning to civil life, we find that our chief hospital in Western Australia has not moved with the times and the same may be said of all our other hospitals. They are deficient in the equipment for modern diagnosis and treatment and also, in some cases, in accommodation. We have recently learnt the cause in the case of the Perth Public Hospital. It appears that the Principal Medical Officer (civil) and the Chief Resident Medical Officer have both given the necessary advice to the Committee, but no action has been taken on that advice. The excuse, as usual, is lack of funds; but I regard this as no excuse when one considers the amount that was subscribed in Western Australia to the Red Cross funds for similar purposes outside the country. It is a matter for regret that His Excellency the Governor-General has seen fit to turn down the recommendation of our local Red Cross Division that £10,000 of the British Red Cross gift of £25,000 for Western Australia be allocated for equipment for modern treatment and diagnosis of disease. This recommendation was, I think, more in accordance with the intentions of the Central Red Cross Society than the purpose to which it is now being allocated, namely, the Bush Nursing Society. Probably the State governments can only be driven to provide efficient sanitary and curative equipment by force of public opinion and this needs propaganda.

The following illustrates the difficulties of civilian administration. In 1896 every bed in the Kalgoorlie

[1] Read at a Meeting of the Western Australian Branch of the British Medical Association on October 20, 1920.

Public Hospital was full, floors were occupied by the convalescents and new patients were daily applying for admission. Repeated application by the District Medical Officer to the Principal Medical Officer and the Premier for increased accommodation met with no response. The District Medical Officer became annoyed, advertised for tenders for a ward of 50 beds, accepted the tender and telegraphed to the Premier: "Wards erected, send beds." Beds were sent without comment. The District Medical Officer than forwarded the bill, which was paid, much to his relief.

(3) Transport.

The transport of sick and wounded became highly efficient during the latter stages of the war. In Western Australia no effort has been made to improve the transport facilities for many years. The time has arrived for efficient motor and railway transport to be organized in Perth and the mining and timber centres, which could easily be done by the provision of sufficient motor ambulance cars and a railway ambulance car; but in order to insure efficiency they should be under the control of the civil medical administration.

(4) Supply of Equipment.

I have already dealt with the lack of equipment in our hospitals; but equipment is also needed for the extension of laboratory and research work, which, I understand, has not been added to for many years. I also think that a complete mobile equipment for the transfusion of blood and gum infusion and oxygen and ether administration, similar to that issued in the Australian Army Medical Corps, should be made available and medical officers trained in their use; this would be of the utmost value in mining, timber and railway accidents. The organization for the prevention and treatment of disease within this State is not entirely satisfactory to the public or the medical profession and certainly does not bring the latest scientific methods within the reach of all. Success during the war in this respect was largely due to the medical services "running their own show" and to the existence of a ready means of getting rid of the "duds." In civil life we find hospitals, convalescent homes and allied institutions controlled by committees composed of persons entirely ignorant of administration, organization and modern medical and surgical requirements.

The war has proved that there is nothing lacking in the skill of the medical profession here as compared with other States. I think that it is time for this Branch of the British Medical Association to give the public a lead. It would be a comparatively simple matter to institute the necessary reforms in this State; but it is, also, an urgent one, in view of a possible large increase of population. I feel sure that if this Branch devised a concrete and workable scheme, the necessary funds would be subscribed by the public, as in the case of the Red Cross during the war. Maintenance and expansion should be provided for by a health tax, which should apply to all. The scheme outlined in the interim report by the Consultative Council on Medical and Allied Services associated with the Ministry of Health in England, modified to the needs of this country, might be successful. Briefly, it consists in the establishment of primary and secondary health centres. The primary health centres correspond to our country hospitals and includes provision for midwifery, operating room, radiography room, laboratory for simple investigation and a common room for a meeting place for the general practitioners of the district and a storage for clinical records. It would also contain accommodation for communal and preventive services, such as pre-natal care, child welfare, medical inspection and treatment of school children, physical culture, dental clinic, etc.. These centres would be staffed by the general practitioners of the district. The patients would be provided at the centres with food, nursing and all equipment for efficient treatment, but not with medical attendance, which would be paid for, either by the patient himself, through some method of insurance, or by the local health authority. The secondary health centres would be situated in a town, such as Perth, where complete and adequate equipment could be available and a sufficient staff of consultants and specialists could be assembled. Both centres would bring together into one organization agencies both of preventive and curative medicine. The scheme also provides local advisory medical councils, part-time consultants, retention by the general practitioner of his own patients, etc.. Laboratory workers and medical administrators would be full-time officers. These officers should be adequately paid. In the past the remuneration of those engaged in the more important task of prevention has been less than that of those merely treating disease.

On the curative side, secondary centres would be mainly of a consultative type and receive patients referred to them from primary centres, on account of difficulties in diagnosis or the necessity of highly specialized equipment. Such an organization, with good administration, would, I think, be acceptable to the public and the medical profession and place the latest methods for the care and prevention of disease within the reach of all.

As regards administrators, the war has proved that we shall have to find our future medical administrators from the ranks of the general practitioners.

Finally, I wish to draw your attention to the matter of army recruits, with which is bound up the question of child welfare and physical culture. It is a matter of common knowledge that the admission to the Australian Imperial Force of men too physically unfit to proceed to the front has cost Australia some millions of pounds, in addition to their pensions. Further, many of those rejected for service in the Australian Imperial Force subsequently enlisted in the United Kingdom and have now returned in receipt of British pensions. It is for us to insist that measures should be taken to prevent such avoidable errors in the future.

AN ANALYSIS OF FIFTY-FOUR CASES OF GUN SHOT WOUND OF THE KNEE-JOINT.

By H. W. Webber, M.S., M.D. (Lond.),
Hobart.

One is anxious that the valuable experience gained in surgery during the war should not be lost to civil

practice. Though the causation of the wound is usually not the same in peace, yet the resultant injuries are probably similar and the knowledge of methods of treatment successful in war surgery will be of benefit.

While serving as officer in charge of the surgical division of a base hospital in France, I collected notes of fifty-four cases of wound of the knee-joint under the care of my colleagues, to whom I am indebted for permission to utilize the records of their work, and under my own care. I propose to analyse the series and to suggest therefrom any conclusions which may prove useful in civil practice.

All the patients of the series were under treatment at the base for a period varying from two days to a month; all had previously received treatment at a casualty clearing station. In every case inflammatory trouble had subsided on transfer to England and it may be reasonably concluded that a useful leg resulted.

In two cases amputation was necessary. In one the operation was performed through the joint sixteen days after the wounding, as the patient was steadily going down hill after excision of the patella and drainage of the joint. In the other a severe compound fracture of the tibia and outer condyle of the femur necessitated amputation through the thigh. In the remaining 52 convalescence was well established on transfer.

Nearly all the patients were treated on a Thomas's hip splint, the advantages of which are well known. The splint was suspended to the roof of the Nissen hut and in all cases the patients expressed themselves as comfortable. In place of the strips of flannel generally used to make the trough in which the limb rests, I would draw attention to the use of perforated zinc. This is supplied in sheets, from which pieces of suitable size can be cut with pliers or bone forceps. They are easily adjusted, the ends being bent round the lateral rods, and are clean and sterilizable, as well as being firm, and one or more sections can be removed with a minimum of disturbance to the patient for dressings to be done. Where considerable damage to the joint had been caused or where the wounds were found to be infected on admission, three or four Carrel-Dakin's tubes were introduced into the joint and the usual irrigation technique performed until the wounds were clean.

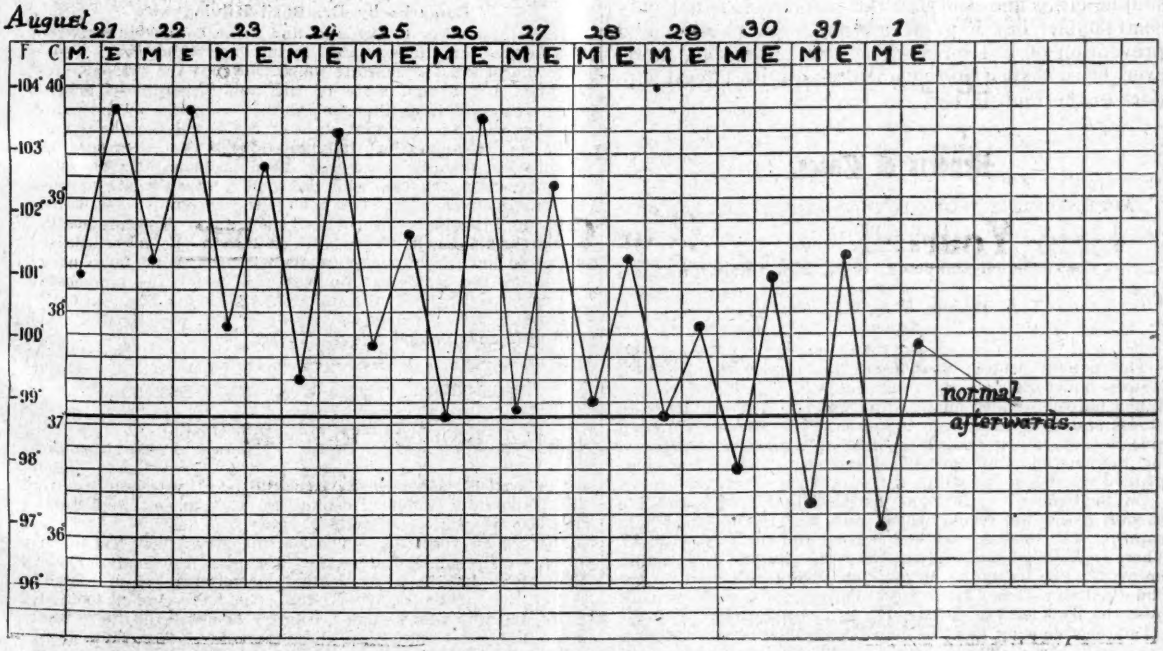
As an illustration of the methods adopted, I will briefly mention a few cases:

No. 12.—Gun-shot wound of the knee. The joint was opened, the wounds were excised; two foreign bodies were removed from the joint; a large hæmatoma was evacuated; the joint was washed out with eusol and sutured. The temperature rose to 37.8° C. for four nights and then remained normal.

No. 16.—Through-and-through wound of the right knee-joint. Clothing and blood-clot were removed from the joint, which was freely irrigated. The capsule was sewn up and a back splint applied. The temperature rose (37.8° to 38.4° C.) for the first week and then became normal. Primary union of wound resulted.

No. 31.—Wound of the knee-joint, with fracture of the head of the tibia. The foreign body was not removed. Bloody fluid was evacuated and a drainage tube inserted. The joint was irrigated with Dakin's fluid and progress was satisfactory.

No. 38.—An interesting case, a punctured wound of the joint being sustained on August 19, 1917. On admission, on August 20, 1917, the knee-joint was moderately distended. About 30 c.cm. of clear, blood-stained fluid was withdrawn by an exploring syringe and was reported to be sterile by the pathologist. Beyond painting with tincture of iodine, no treatment, except rest on a back splint, was adopted. No increase in the effusion into the joint took place and it gradually subsided, being completely absorbed in about 12



Temperature Chart (Case No. 38).

days. The febrile disturbance is shown on the accompanying chart.

No. 44.—Perforating wound of the left knee; fracture of the external condyle; hole in the femur. A foreign body was removed from the supra-patellar pouch of fat. The joint was washed out, the wounds were excised and the capsule was closed. A glove drain was inserted down to the capsule. Progress was uninterrupted and primary union resulted.

Remarks.

In considering these cases, one is struck by the success of the methods adopted and the tolerance of the knee-joint to aseptic surgical interference. It must, of course, be borne in mind that the patients were young, healthy men, trained to the best possible condition by physical drill, good food and life in the open air, but the results, as compared with pre-war experience of civil hospital practice, are none the less remarkable.

I received my surgical training in the "antiseptic" days of the carbolic acid spray and irrigating lotions; the methods so successfully practised in the great war would appear to be but a return—with improvements and modifications—to the old Listerian technique of the last century.

To any surgeon not habituated to the use of Thomas's splint, I would strongly urge its many advantages, not only in such cases as described in this series and for the method of treatment of hip-joint disease for which its originator designed it.

Cases of fracture of the femur, patella or leg bones do excellently on it. In compound fracture the necessary interference for dressing is reduced to a minimum, as a section of the perforated zinc plates has simply to be removed and readjusted. The degree of extension of the limb is easily adjustable by rubber drainage tube over the foot bar. In an out of the way district it can be readily made. It is simple, clean and cool and the suspension is not only comfortable, but a great assistance in nursing and prevention of bed sores. The zinc plates can, moreover, be so shaped and moulded as to give lateral support to the limb in cases of fracture.

Reports of Cases.

APPENDICITIS, FOLLOWING DYSENTERY AND PAROTITIS.

By **Eric H. Gandevia, M.B., B.S. (Melb.),**
and
T. G. Wynne, M.B., B.S., (Melb.),
Nauru.

The patient whose complicated and interesting medical history is described in the following was a native of Nauru. When he came under our care he was convalescent from an illness stated to have been influenza. This disease had been epidemic in Nauru. Later he had an attack of dysentery. His motions had contained blood and slime and he had complained of abdominal pain.

On September 29, 1920, he had a slight cough and his parotid gland was very swollen and hard. The gland was painful. The temperature was normal and the pulse-rate 80. There was no abdominal pain and the bowels were acting normally. Examination of the chest did not reveal any abnormal condition. There were, however, a few râles heard over the back of the chest.

On the following day the parotid gland was still swollen, hard and tender. The patient passed frequent motions containing dark blood in considerable quantities. The temperature was 37.2° C.. He complained of general abdominal pain, chiefly on the left side.

Examination showed slight general abdominal tenderness, especially along the course of the descending colon. There was no rigidity of the abdominal muscles. He was sent to hospital, a distance of about eight kilometers, by motor car. On his arrival he complained of severe pain in the lower segment of the abdomen on the right side. As far as could be ascertained through the interpreter, this pain had come on suddenly during the afternoon.

By this time his temperature had risen to 38.3° C. and his pulse-rate was 90. His tongue was moist and furred. The abdomen was very tender, especially in the region of McBurney's point. There was general muscular rigidity, chiefly over the right side of the abdomen. A few râles were heard an auscultation of the chest. We determined to operate at once.

Under chloroform anæsthesia the abdomen was opened through a McBurney's incision. As soon as the peritoneum was incised, it was seen that the whole of the abdominal contents in the region of the caecum was adherent and matted together. The adhesions were separated and immediately a small quantity of foul-smelling pus was evacuated. Attempts to bring the caecum out of the abdominal cavity proved unavailing. The appendix was found after some searching. It was kinked at about its centre and a perforation was discovered at this situation. The appendix was removed and drainage tubes were inserted. The wound was closed in the usual manner.

The patient's condition after the operation was remarkably good. The pulse-rate was 86 and its volume satisfactory. On the following day the patient seemed to be comfortable. He had spent a moderately good night. The dressings were changed 24 hours after the operation. There was a slight discharge from the drainage tubes. The abdomen was lax and there was no pain. The pulse-rate was 90.

During the day the patient passed two soft, solid motions without any blood. It was noted that the swelling of the parotid gland was beginning to soften at its centre. On the following morning the parotid abscess had burst. The patient was restless and delirious. His temperature was 38.9° C. and his pulse-rate 120. Many râles and crepitations were heard over the posterior regions of the chest on both sides. He became progressively weaker and died at mid-day. Permission to examine the body was unfortunately refused.

Remarks by Dr. Basil Kilvington.

It is interesting to try and find some connexion between the various conditions present in this interesting case. Probably the original dysenteric illness lowered the patient's resistance and a foul state of the mouth permitted organisms to ascend along Stenson's duct, giving rise to the parotid abscess. An abnormal state of the bowel flora is apt to light up an appendical inflammation if that structure be abnormal. Usually there have been previous attacks, mild or otherwise. Anyone who has had a troublesome appendix, appreciates the extra ache and discomfort associated with an intestinal disturbance, such as is associated with a diarrhœal attack. The fatal ending in the present case seems to have been a septicæmia with the usual pulmonary signs and the septic parotid was most likely the immediate portal of entry for the micro-organisms. The patient's resistance was poor as the result of the prolonged illness and numerous complications.

FULL-TERM EXTRA-UTERINE GESTATION.

By **H. Stubbe, M.B., B.S. (Melb.),**
Senior Resident Medical Officer, Fremantle Public Hospital.

The patient, a primipara, aged 19 years, was admitted to the Fremantle Public Hospital at 11 a.m. on September 20, 1920.

History on Admission.—The last menstrual flow had taken place on December 7, 1919, *i.e.*, 286 days previously. Since then there has been no vaginal hæmorrhage of any kind. About the middle of March, 1920, she had some abdominal pain; she was admitted to a country hospital and there was some talk of terminating the pregnancy. The pain soon ceased, however, and she was discharged without anything being done.

Pregnancy continued in an apparently normal manner until August 31, 1920. She then had a severe attack of abdominal pain, which she referred to the region of the umbilicus. Dr. Blackall was called in; he examined and treated her. Since then she has had three similar attacks, each lasting about two days.

On September 20, 1920, the pain became agonizing. It was of a bearing-down character. The patient vomited large quantities of greenish fluid. Dr. Blackall was again called in. He told her that she must be operated on immediately and sent her to hospital.

Condition on Admission.—The patient was a small, thin woman. She was pale and clammy and apparently in great pain. The pulse-rate was 134. the temperature was 36.8° C. and the respirations 32.

The abdomen was of irregular shape; the protuberance was most marked in the upper portion. On palpation the fœtal parts were felt through a very thin abdominal wall, as distinctly as if they had been covered by a thick cloth only. Above the umbilicus the head, shoulder and elbow, below the umbilicus, the knee, the ball of the heel and the toes, could be easily and quite definitely recognized. Movements were continuous and vigorous. There did not appear to be any engagement in the pelvic brim. The abdomen was tender all over.

Examination *per vaginam* revealed a soft, closed cervix; the fornices were clear; the fundus could not be located; there was no presentation of fœtal parts.

Diagnosis.—A provisional diagnosis of extra-uterine pregnancy was made.

Operation.—Dr. Blackall was assisted by Dr. East. A long median incision was made. When the peritoneal cavity was opened the child was immediately visible, lying free in the abdomen among the intestines. Its head was in the left epigastrium, its breech in the right iliac fossa; it was lying on its right side, with its left shoulder and left hip uppermost. Round the child's trunk was a broad belt of fibrous tissue, reaching from its axillæ to its groins; this was attached to and apparently continuous with the left broad ligament. The peritoneal cavity contained meconium and amniotic fluid.

The cord was clamped and divided and the child removed. It slowly responded to prolonged resuscitation by Drs. Stubbe and Tregonning. It was a healthy child; weight at birth, 3 kilograms.

The placenta was found to be enclosed in a fibrous sac. This sac was quite movable and was attached to the left side of a slightly enlarged uterus by a wide pedicle. The left tube, ovary and round ligament were not noticed at the time of operation. The pedicle of the placenta was ligatured and divided; the sac containing the placenta was then lifted freely out of the abdomen. Meconium was mopped up and the abdomen closed. The uterus and its appendages on the right side remained intact.

The mother made an uninterrupted recovery; the child is now a fat boy of considerable lung power.

Discussion.

We consider that this was a case of ectopic gestation ruptured into the left broad ligament.

The placenta and its coverings have been preserved. Examination of the sac shows the presence in its walls of the tube, ovary and round ligament. As the fœtus developed it evidently dilated the broad ligament into a sac, which at first contained the child, in addition to giving attachment to the placenta. At a later date the child partly escaped from these coverings, which remained only as a wide band of tissue around the trunk, leaving the head and limbs free.

The left broad ligament, containing placenta, tube, ovary and round ligament, was removed *in toto*.

Reviews.

ANÆSTHETICS.

The sixth edition of Dr. Buxton's treatise on anæsthetics[1] is based in general upon previous edition of this well-known work. The subject matter has been thoroughly revised and considerably enlarged, full use having been made of the experience gained in the great war in regard to anæsthesia.

The value of intratracheal and intrapharyngeal insufflation of ether has received due attention and some of the recently introduced mechanical apparatus are admirably figured and described. In the section dealing with gas-oxygen anæsthesia full advantage is taken of the experiences gained during the war in the application of this method to cases of profound shock.

Severe hæmorrhage and shock as complications of surgical procedures are discussed with special regard to their bearing on anæsthesia.

In considering the relative values of the various anæsthetics and apparatus in common use, the author wisely refers to the advisability of avoiding a routine choice of anæsthetics, recognizing that many reliable methods of anæsthetization exist and that an efficient administrator should be capable of fitting the appropriate means to each individual case. The principles of local analgesia and spinal anæsthesia are fully dealt with in a separate chapter.

The book is thoroughly up to date; it is admirably produced and may be confidently recommended as a reliable text-book of anæsthesia.

[1] Anæsthetics, Their Uses and Administration, Sixth Edition, by Dudley Wilmot Buxton, M.D., B.S.; 1920. London: H. K. Lewis & Co., Ltd.; Demy 8vo., pp. 548, with 97 illustrations, including 8 plates. Price, 21s. net.

Notes on Books.

MORE ABOUT GUM NUTS.

When Miss May Gibbs presented us with that quaint prose epic of the Gum Nuts, "Snugglepot and Cuddlepie," some twelve months ago we welcomed her as a great physician who drove dull care away. She has increased her eminence as a dissipator of gloom by the production of a sequel[1] to that little work. This time little Ragged Blossom is the prima donna and Snugglepot and Cuddlepie are her faithful knights and servitors. The theme is concerned with a wicked plot concocted by the bad Banksia men, headed by their ferocious Captain to decoy the three Gum Nuts aboard *The Snag* and when the moon is gone and the dark nights come to throw them into the sea. With the aid of Winkey, a friendly rat, they frustrate this diabolical scheme and escape to land. Cuddlepie, after a vain effort to earn a living as an artist, who paints his masterpieces on the foot-path, is pitied and adopted by a compassionate, elderly Nut. Snugglepot applies for a position as dispenser to the eminent physician, Dr. Honkus Ponkus, passes a rapid but exhaustive examination with high distinction and is given the job. Ragged Blossom, profiting by her unadorned beauty, earns an honest penny as an artist's model. Soon she becomes very drowsy and, as the good folk at the studio cannot awaken her, Dr. Honkus with his assistant is called in to prescribe. The great doctor fails to diagnose anything more serious than sleep and departs. Snugglepot stays behind to awaken Blossom and the bold, wicked Captain, who has been prowling around, enters, puts them into a bag and throws them over a cliff into the sea. Of their innumerable adventures among the denizens of the deep and of Snugglepot's ultimate resurrection on a fish hook into the bright sunshine and air again only to undergo greater perils from the Banksia men before he is reunited to Cuddlepie, the reader may learn for the very modest investment of six shillings. Little Ragged Blossom remains with her fish friends under the sea, so we may hope to be served with fresh thrills in a further sequence next year.

Miss Gibbs's book is ostensibly a Christmas treat for the young folk, but even old fogies would need to be very sour and crusty not to admit that they enjoyed every word of it. Apart from her charming humour and style, Miss Gibbs is a homely naturalist of class. She knows every leaf and twig of the Australian bush and, judging from her knowledge of sea comets, anchovies, anemones and the like, she would seem to have spent at least half her life down in the mysterious deep. The whimsical illustrations compete for

[1] Little Ragged Blossom and More About Snugglepot and Cuddlepie, by May Gibbs; 1920. Sydney: Angus & Robertson, Ltd.; Crown 4to., pp. 98, with 40 illustrations. Price, 6s.

supremacy with the text. Some of them are in colour, but all of them bring a sparkle of merriment into the eye and a chuckle into the throat. We wish this delightful little volume a happy voyage into every Australian home.

DINNER TO DOCTORS J. R. HARRIS, M.L.C., AND STANLEY ARGYLE, M.L.A.

The members of the Victorian Branch of the British Medical Association entertained Doctors J. R. Harris, M.L.C., and Stanley S. Argyle, M.L.A., at dinner on November 26, 1920, at the Grand Hotel, on the occasion of their election to Parliament.

The President, Mr. G. A. Syme, acted as host. A large number of members were present.

In replying to the toast "Parliament," proposed by Dr. Norman McArthur, Dr. Earle C. G. Page, M.H.R., referred to the difficulty experienced by medical practitioners to find time to enter upon a political career. He claimed that by training and experience medical men were peculiarly fitted for legislative work. He commended to medical practitioners generally and country practitioners in especial active participation in civic affairs.

Mr. Syme expressed his gratification at the election of their guests to Parliament. His pleasure was enhanced by the fact that both had been among his earliest students. Mr. Syme eulogized the qualities of both Dr. Harris and Dr. Argyle and also referred in appreciative terms to the valuable work that Dr. Earle Page had carried out in the political world.

The toast of "Our Guests" was placed in the hands of Dr. Basil Kilvington He dwelt on the qualifications required for a medical member of Parliament and pointed out that both their guests possessed these qualifications, developed to an unusual degree. Both were returned men, both had had considerable experience in the practice of their profession and both were well known to their colleagues as men of high character and integrity.

The toast was supported by Dr. A. V. M. Anderson and was received with enthusiasm.

Dr. J. R. Harris thanked the members for the cordial reception they had accorded him. He expressed the opinion that the medical profession should be better represented in the legislative bodies. Medical men had the advantage of seeing both the seamy and the better side of life and consequently ought to possess a humane and broad outlook. He considered that a medical man should take up the burden of his own section of the community and assist in the development of the State and of the Commonwealth. The profession should take a leading part in the campaign for saving life and in movements like those of child welfare, the combating of venereal disease, the control of the public health and the like.

Dr. S. S. Argyle, after having thanked his colleagues for the manner in which they had responded to the toast and after having dealt lightly with his brief experience of public life, turned to some of the subjects of immediate concern to the medical profession. He had been amazed at the intense hostility shown by a section of the members of Parliament to the *University Bill*. Those who objected, claimed that this measure had been designed in the interests of city industries. He emphasized the great importance of giving attention to the centres of learning, if they desired to compete with other nations.

THE EDUCATION ACT OF SOUTH AUSTRALIA.

A new set of regulations under the *Education Act, 1915-1919*, have been drawn up and will take the place of all previously issued regulations under the same Act. These regulations have been printed in the *South Australian Government Gazette* and, together with the schedules, occupy 30 pages of print. There are 15 regulations dealing with infectious and contagious diseases. Teachers are required to inspect all children under their charge at each morning assembly with the object of securing perfect cleanliness and detecting indications of disease. Any child whose presence might be injurious to the health or welfare of other children shall be sent home and excluded from school attendance until the condition of body or clothing on account of which the child was excluded from school, shall have been remedied. The Medical Inspector may enter a school at any time and examine any of the children. The teachers are required to follow the advice of the Medical Inspector in regard to the exclusion or re-admission of any child.

A teacher shall exclude a child from school if he has reason to suspect that the child is suffering from pertussis, morbilli, scarlet fever, diphtheria, enteric fever, influenza, tuberculosis of the lungs or larynx, variola, favus, varicella, parotitis, ringworm or scabies, or if he has reason to suspect that any of these diseases exists in the home of the child. The period of the exclusion in cases of suspected illness is fixed for each illness and varies from two days to one week. Apparently the teacher is required to follow the instructions given in the table in cases when he has reason to believe (not suspect) that the child is suffering from one of the named diseases. There is, however, a saving provision to the effect that the action of the teacher shall be subject to any special instructions that may be given. The teacher is required to notify the Director of Education in urgent cases by telegram and otherwise on the prescribed form when a case of communicable disease arises in the school. He shall also report the matter to the Secretary of the local Board of Health. Not only is a child excluded from school when someone residing in the same house is suffering from a communicable disease, but its exclusion is also required when it has visited a house in which someone is suffering from such a disease or has attended the funeral of any person who has died from one of the diseases named.

When the number of children attending a school is reduced to one half or less on account of an outbreak of pertussis, morbilli or scarlet fever, the teacher is required to report the fact to the Director of Education. If, for some special reason, it appears to a teacher that a school should be closed, the teacher shall report by telegram to the Director. It is, however, determined that no school shall be closed, except for disinfecting purposes, without the express sanction of the Minister. A further regulation deals with the contingency of the exposure of a teacher to infection.

It appears that the Executive Council, in sanctioning these regulations, has deliberately ignored the machinery existing in the medical branch of the Education Department. Throughout the regulations, there is constant reference to the actions required of teachers when they suspect or believe that a child is suffering from an infective process, or has been in contact with a patient suffering from one of these diseases. From the point of view of the individual it is obviously necessary that a medical practitioner should be consulted in the patient's home. The suspicions and beliefs of the teacher would be of small moment if a medical practitioner ascertained the presence or absence of any of the notifiable diseases and notified the health authority in accordance with the provisions of the *Health Act*. From the point of view of preventive medicine, we miss in the regulations all reference to any obligation on the part of the teacher to secure the assistance and guidance of the medical officers of the Education Department. As an appendix to these regulations, some general directions in regard to communicable diseases are published. These directions are supposed to be for the guidance of teachers. A few extracts from a pamphlet on communicable diseases prepared by the Chairman of the Central Board of Health are reproduced. We would suggest that it is an extremely dangerous procedure to stimulate the teacher to endeavour to arrive at a diagnosis in the case of obvious illness and to act upon suspicion or belief. Surely, it would be wiser and safer to require the teachers to call in a medical practitioner in all cases of obvious febrile disturbance, so that a definite diagnosis may be made by someone competent to form an opinion.

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The Medical Journal of Australia.

SATURDAY, DECEMBER 25, 1920.

The Allied Sciences.

There is a tendency abroad among the members of the medical profession to be intolerant of interference in all branches of science involved in medicine. We admit that medical knowledge is based on chemistry, physics and zoology, and yet the non-medical chemist, physicist or biologist is usually ignored or even told to mind his own business when medical problems are under investigation. It has been pointed out in these columns that it would be advantageous if every teacher in the medical school had passed through the full medical curriculum, so that he would be in a position to appreciate the limits of what may be termed medically applied chemistry, medically applied physics and medically applied biology. This is obviously a matter of expediency. The professor of chemistry would find it difficult to determine how much or how little pure chemistry the medical student requires for a proper understanding of those processes which govern the function of the cell. Unless he possessed a wide knowledge of physiological and pathological chemistry, he would tend to give instruction in very elementary science and to introduce details concerning chapters of chemistry not even remotely connected with medicine. Similarly a non-medical expert teaching physics rarely has any conception of the extent of physical knowledge that should be taught to medical students. It requires an extensive and intimate knowledge of the physical problems in cellular physiology, of the dynamics and mechanics of the body fluids and muscular organs and of the physical basis of many pathological states to appreciate the extent of training in this science needed by medical students. The same disadvantages obtain when the non-medical biologist endeavours to select from his wider range of information the kind and amount of knowledge suited to medical education. For these reasons we have advocated that the experts responsible for the teaching of these sciences to medical students should themselves have studied medicine in all its branches. There is, however, another aspect of this question which should be examined with care. As new problems are attacked and fresh avenues of research are opened, the range of knowledge of pure chemical, physical or biological science involved is gradually extended. The expert in medical chemistry blocks the course of progress in his own field if he neglects to confer from time to time with the non-medical chemical expert. The same applies to both the physicist and the biologist. Life is too short for any one man to command expertness in all branches of medicine and of the allied sciences. In a few institutions, like the Lister Institute of Preventive Medicine, non-medical chemists are appointed to conduct bio-chemical research in connexion with pathological problems. It is, however, very rare indeed, for medical practitioners engaged in research to seek the collaboration of the non-medical expert in the one or other of the fundamental sciences. It must never be forgotten that Pasteur, to whom medicine owes the possibility of bacteriology, was not medically trained. Many of the problems of medicine are so closely shrouded in mystery that a solution can only be expected if a co-ordinated effort is made to investigate every aspect. We should not hesitate to appeal to the great chemical, physical, zoological and botanical institutions of the Commonwealth for assistance in wresting her secrets from Nature. The objections raised in the case of the teacher of students to the non-medically trained scientist do not obtain when collaboration can be offered by the skilled medical research student. There are many hiatuses in medical information that could be filled with comparative ease, if the problems could be presented by the medical expert to the pure chemist, physicist or biologist. It needs but a slight modification of the position adopted by the members of the medical profession to institute an admirable system of co-operation and combined endeavour. We are convinced that the scientists in our universities and in the State-supported museums and analogous institutions will not hesitate to lend their aid if it is frankly sought.

CHRONIC NEPHRITIS.

The pathological basis of chronic nephritis has been the subject of strenuous debate for many decades. Prior to the year 1872 it was generally accepted

that chronic nephritis was a primary disease of the kidneys and that the circulatory changes which are so pronounced a feature of the disease, were secondary manifestations. In that year two English physicians, Gull and Sutton, broke away from this teaching and, while denying that the primary lesion was in the kidneys, argued that it was to be found in the vessels of the circulatory system. They assumed that chronic interstitial nephritis was always preceded by a more or less generalized arterio-sclerosis (arterio-capillary fibrosis) and that the secreting tissue of the kidney suffered secondarily as a result of the sclerotic changes in the finer renal vessels. One form of chronic kidney disease gave considerable weight to their opinions. They described a form of nephritis which goes by the somewhat loose title of "arterio-sclerotic kidney." In this condition the patient often died without any suspicion on the part of the physician that the kidneys were diseased. The amount of urine passed was normal, its specific gravity was often over 1,020, casts were frequently difficult to find and the quantity of albumin present was far in excess of that usually found in typical cases of chronic interstitial nephritis. Moreover, whereas in the latter disease there were evidences of high blood pressure with hypertrophy of the left ventricle (said to be due to the contraction and partial obliteration of the arterioles in the renal substance), in the arterio-sclerotic form the symptoms were those of heart failure and the death was clinically of cardiac origin. Yet at autopsy the kidney was found to be extensively diseased. It was large, hard and red and certain vascular areas were found to be the seat of extensive fibrosis. Here, then, was a form of recognized kidney disease in which the renal changes appeared to be definitely secondary to a generalized arterio-sclerosis. A strong battle of opinion has raged around these views and it may be said that, on the whole, the spoils of victory have gone to the opponents of the Sutton-Gull hypothesis.

Now enters into the field a fresh champion of the less popular cause. Dr. Eli Moschcowitz,[1] of New York, in an examination into the clinical and anatomical relations in chronic nephritis, concludes that it is a vascular disease and that where the clinical picture is of the "renal type," the primary lesion is not in the kidney substance proper, but in the glomerular capillaries, extending thence to the larger vessels. He argues that chronic nephritis and arterio-sclerosis are one and the same process and that the clinical picture depends on which part of the vascular system is attacked. For example, the arterio-sclerosis may be generalized, with no special involvement of the renal vessels, or it may be more or less localized to the cerebral vessels (producing cerebral endarteritis and apoplexy), to the coronary vessels (myocarditis), to the retinal vessels (albuminuric retinitis) or to the arterio-capillary system of the kidney (chronic nephritis). He assumes the existence of an "essential hypertension" which precedes these arterio-sclerotic changes and leads to their formation. There is no proof adduced that a high blood pressure is an antecedent manifestation to the degenerative changes in the vessels. He states it as a belief. There is no attempt at proof and, indeed, it is hard to see how the truth of his assumption could be established. But admitting the existence of hypertension prior to the development of nephritis and arterio-sclerosis, we are still confronted with the problem of the cause of the hypertension. Dr. Moschcowitz calls it "essential" hypertension, by which we assume he means that its cause or causes are unknown. He has made no attempt to investigate the cause of this preliminary high blood pressure, nor does he touch on the investigations of other workers in this regard. It was suggested many years ago that chronic interstitial nephritis was caused by the production and passage into the blood of certain chemical substances capable of raising the arterial blood pressure. These pressor substances were said to be produced by the kidneys and the suprarenal glands. That the suprarenal glands show hyperplasia in certain cases of chronic nephritis has been well established and it has been claimed that adrenalin, whose action on the blood pressure is classical, is present in the blood in certain cases of this disease. Nevertheless, there is still lacking definitive proof that these or any other substances produce a primary hypertension. Dr. Moschowitz assumes that an essential hypertension exists and on this assumption he builds the main superstructure of his argument. Much as we may doubt the strength of the foundation, we cannot deny that the house is well constructed.

He points out that the present pathological differentiation of chronic nephritis into small white kidney, small or large red kidney, granular contracted kidney, etc., is dissonant from clinical findings. The clinician, for example, who predicts that a large red kidney will be found *post mortem*, too frequently finds that the morbid anatomist disproves his diagnosis. But if we view the disease as an evolution of changes beginning with a sclerosis of the glomerular vessels (glomerulo-nephritis) and ending with the state of granular contracted kidney when the renal tissue, considerably deprived of its blood supply, is shrunken and fibrous and, secondly, if we remember that death, whether from uræmia, cerebral hæmorrhage or myocardial failure, may occur at any stage of this evolution, then we may more easily reconcile the clinical study of the disease with the pathological. Here we have a suggestion which is certainly inviting. If true, it is a simple and acceptable solution of the problem. Other observers, however, hold that the various forms of chronic interstitial nephritis are more or less distinct types and not stages of the one process. Unfortunately there is no means of gauging the correctness of either view. Both are merely opinions. But obviously the responsibility of proof rests with the protagonists of Dr. Moschcowitz's theory, since they presuppose a connexion between apparently different pathological processes.

Dr. Moschcowitz suggests that the term "chronic nephritis" is often used when the clinician is really dealing with "renal insufficiency." He makes good use of an analogy from heart disease. When a valvular lesion of the heart is "compensated," clinical tests show no evidence of renal insufficiency. When circulatory insufficiency sets in, renal insufficiency is made evident by the presence of oliguria, albu-

[1] *Archives of Internal Medicine*, September 15, 1920.

minuria and casts in the urine, signs undistinguishable from those associated with chronic nephritis. Should compensation be now restored by the use of rest and digitalis, the evidences of renal involvement will disappear.

The author has handled a difficult subject in an able fashion. Many will doubtless accept his views as a very reasonable explanation of the problem. More evidence is necessary, however, before he can hope to convince the general body of medical opinion.

DISEASE OF THE PANCREAS.

The study of the diseases of the various internal organs demands the combined efforts of the clinician, the pathologist and the bio-chemist. When each of these experts attacks the problem individually and independently, erroneous conclusions may be expected. Even when many facts have been collected as a result of careful observation and ingenious experimentation, it requires a very nice adjustment to accord to each datum its true significance. The difficulties surrounding the elucidation of the signs and symptoms of disorders and pathological conditions of the abdominal organs are necessarily considerable. In the case of the pancreas they have hitherto proved immense. Thirty years ago the diagnosis of acute pancreatitis was occasionally made in connexion with pyæmia, septicæmia and enteric fever. The clinician built up his opinion on signs such as epigastric tenderness, pain and tumour, in the presence of symptoms such as thirst, vomiting and constipation. The recognition of an acute inflammatory process was of small moment during life. The occasional association of chronic pancreatitis and diabetes was recognized, but at that time this association was regarded as accidental by the majority of clinicians. Lépine was probably the first to point out that a disturbance of the normal function of the pancreas led to the appearance of sugar in the urine. It was held that the pancreas furnished an internal secretion which governed to some extent the metabolism of glucose. Shafer examined the pancreas in order to establish this hypothesis and adduced evidence to show that the function of the islands of Langerhans was to effect a splitting of the sugar in the blood. Later Minkowski demonstrated that removal of the whole organ resulted in diabetes. F. M. Allen has gone a stage further and has proved that the glycolytic function can be disturbed by the removal of portion of the pancreas and that glycosuria can be induced in an animal deprived of 77.5% of its pancreas, if the quantity of carbo-hydrate ingested is relatively large. Concerning the physiology of the pancreas in relation to digestion, it has long been known that its ferments react on proteins, carbohydrates and fats (Claude Bernard). In the next place the pathologists were able to describe the changes in the gland in inflammatory conditions and when involved in malignant disease. We have thus some information concerning the clinical aspects of pancreatic disease, concerning the changes found after death in these conditions and concerning the bio-chemistry of the urine and fæces. But a proper co-ordination of the scraps of information hitherto collected is wanting. Allen has made a bold bid to approach the subject by studying the chemical and clinical aspects of diabetes, but a great deal of his teaching is based on insecure foundation, inasmuch as there is a very vast difference between the physiological exclusion of a part of the pancreatic function resulting from a pathological process and a mechanical removal of a portion of the healthy gland.

It would appear as if some material progress were being made in the endeavour to reconcile the pathological processes affecting the pancreas and their clinical manifestations. A relatively large number of chemical tests have been introduced which are supposed to indicate the functional condition of the pancreas. These include a group of tests aiming at the measurement of the proteolytic action of the pancreatic juice, such as Schmidt's test and its many modifications, Sahli's test, the trypsin plate test and the casein test. In the next place there are the tests for the estimation of the fat content of the fæces and the diastase tests. In the last place there has been introduced a large number of methods for estimating the functions of the pancreas other than the digestive. Some of them have already been discarded, notwithstanding the ingenuity on which they depend. Thus Cammidge devised a "pancreatic reaction" after much thought and careful experiment. It does not reveal defective pancreatic function, as was the intention of its originator. Other tests are still on trial, such as Loewi's mydriasis test. This test depends on the fact that adrenalin instilled into the eye of normal healthy subjects produces no effect, while dilatation of the pupil follows in persons suffering from certain diseases. Loewi introduced the test as an indication of the disturbance of the action of the secretion of the supra-renal bodies when uncontrolled by pancreatic secrtion.

A very valuable investigation has been carried out by Dr. R. L. Mackenzie Wallis, who has applied the greater number of the tests in eight cases of acute pancreatitis, in 28 of chronic pancreatitis, in five of carcinoma of the head of the pancreas, in 20 of diseases of the liver and in 31 of other diseases.[1] The tests have been applied in conjunction with the physicians of Saint Bartholomew's Hospital and their significance has been adjudged after careful consideration of the clinical history, course of illness and, when possible, *post mortem* findings. It became evident at an early stage that the direct estimation of the tryptic action of the pancreatic juice by any test applied to the fæces must fail on account of the long journey the intestinal contents have to make after coming into contact with the pancreatic ferments. During the course of this tortuous voyage, the contents are exposed to so large a variety of influences, that the measurement of the effect of a single ferment has became physically impossible by the time of their emergence from the rectum. Dr. Mackenzie Wallis finds that no one test is a reliable indicator of pancreatic insufficiency. But he has learned that the combination of an increased amount of diastase in the urine, mydriasis on the application of adrenalin to the eye and the presence of sugar

[1] *The Quarterly Journal of Medicine*, October, 1920.

in the urine justifies the physician in placing the pancreas under strong suspicion. This suspicion is materially increased when there is creatorrhœa and steatorrhœa. In ascertaining the existence of the former, the recognition of undigested muscle fibres in the fæces is perhaps the most valuable indicator. He warns the bio-chemist and the physician that the phenomena involved in these tests are often transitory and that they usually disappear in the advanced stages of disease. Further studies on these lines may be productive of useful results, both in regard to the diagnosis of disease and in the determination of the underlying pathological processes.

MEDICAL DEFENCE ASSOCIATION OF SOUTH AUSTRALIA.

The annual meeting of the Medical Defence Association of South Australia was held in the Lister Hall, B.M.A. Building, Hindmarsh Square, Adelaide, on December 2, 1920.

All the office-bearers were re-elected, including Dr. H. Swift, the President. Drs. A. A. Lendon and F. S. Scott retired from the Council and Drs. R. Magarey and E. Brown were elected in their stead. The following report of Council was read:

Report of Council, 1920.

Your Council is glad to report that members have not required assistance to any great extent during the past year.

In one case, where a member had been summoned by a health authority for a belated notification of infectious disease, the Association was able to give some much-appreciated advice and assistance.

During the past month two other members have requested aid from the Association in much more serious difficulties than the preceding and these cases are still under consideration.

Our funds have satisfactorily increased and our expenses this year have been nominal.

We record, with much regret, the death of Dr. W. V. Drew, of Bordertown.

There has been a satisfactory increase in our membership during the year.

H. SWIFT, President.

The Honorary Treasurer submitted an audited statement of receipts and payments. The receipts during the year amounted to £313 2s., including subscriptions aggregating £64 16s. 6d.. The expenditure for the year was £8 14s. 9d., including £1 11s. 6d. for legal assistance. The sum of £150 was invested in the Peace Loan. The assets of the Association amounted to £1,484 7s. 3d. on November 22, 1920.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association.

S. H. Scougall, Esq., M.B., 1920 (Univ. Sydney), 394 North Sydney.

T. W. Freeman, Esq., M.B., 1919 (Univ. Sydney), "Ben Lomond," Blaxland Road, Ryde.

R. J. Murphy, Esq., M.B., Ch.M., 1918 (Univ. Sydney), Longueville.

Medical Societies.

MELBOURNE PÆDIATRIC SOCIETY.

A meeting of the Melbourne Pædiatric Society was held at the Children's Hospital, Carlton, on October 13, 1920, Dr. A. E. Rowden White, the President, in the chair.

Mr. W. Kent Hughes presented a boy, aged 7, whose case was illustrative of a good result attending the operation of thyrotomy. The history was as follows: Four months before his admission to the Children's Hospital on August 30, 1920, he had contracted laryngeal diphtheria, involving tracheotomy as an operation of urgency. After this the child was sent to the Fairfield Infectious Diseases Hospital, where he remained for six weeks. In the interval between his discharge from Fairfield and his admission to the Children's Hospital he had suffered periodic attacks of laryngeal distress. On the occasion of his admission the child was in acute respiratory difficulty, for which intubation was unsuccessfully attempted, the efforts to pass the tube disclosing by palpation that the glottis was very œdematous. Tracheotomy was therefore performed and gave immediate relief.

On the following morning the boy was in good condition and quite comfortable, but could not tolerate the removal of the tracheotomy tube. The tube was not taken out again until two days later (September 2, 1920). After its removal the child remained comfortable for a few hours, but at the end of this period respiratory distress and cyanosis necessitated the replacement of the tube. On September 5 the tube was taken out at 11 a.m., but it was necessary to reinsert it at 7.30 p.m..

An X-ray examination of the neck revealed nothing abnormal. Laryngoscopic examination on September 14 demonstrated that the obstruction in the larynx was due to cicatricial tissue. On September 21 Mr. Kent Hughes operated under general anæsthesia. The thyreoid cartilage was divided in the mid-line by extending the tracheotomy wound upwards. The false cords were found glued together, thick and hypertrophic, with large, fibrous, polypoid masses attached. After the removal of the latter, an intubation tube was inserted and the wings of the thyreoid cartilage sewn together with interlaced catgut. On the two successive days immediately following the operation the tube was coughed out and re-inserted. Eight days later the tube was removed and not replaced. The boy remained quite well. At the time of the meeting his neck wound was healed and his voice was daily becoming stronger.

Mr. Kent Hughes remarked that the case had been one of difficulty from the beginning. At the outset he had been unable to separate the arytenoid cartilages sufficiently to introduce a small tube. The operation was undoubtedly made less troublesome by extending the tracheotomy wound. He thought that eventually the boy would have a good voice. The important point in the technique of the operation was that the surgeon should keep exactly to the middle line.

Dr. Wm. Dismore Upjohn, O.B.E., observed that only the lapse of time would show whether the boy would remain free from laryngeal stenosis. On analogy with experience in other parts, such as the urethra, where dilatation by tubes was utilized to mitigate the effect of a fibrous stricture, there would seem to be a probability of a recurrence of the obstruction. Possibly the rigid walls of the thyreoid cartilage afforded an anatomical basis for the hope that the tendency for stricture to recur noted in the case of other tubular structures, might not reveal itself in the larynx.

Dr. H. Douglas Stephens remarked that he had recently seen a pattern of intubation tube in which the swell present in the O'Dwyer type was reduced to a minimum. It was claimed for this design that it was less prone to lead to the state of affairs connoted by the term "retained tube."

Dr. F. Kingsley Norris thought that a great deal of the trouble sometimes encountered after intubation was to be referred to the gradations in size of the tubes composing the ordinary intubation set. O'Dwyer's tubes were standardized from casts of the larynx at different ages, but no account was taken of inflamed larynges. Almost every larynx needing intubation was more or less œdematous and the selected tube for the individual was therefore likely to be too large. He was of opinion that the usual standard of tube, in that it was not accurately accommodated to an inflamed larynx and consequently led to trauma, was an important factor in the production of laryngeal stenosis after intubation.

Dr. W. S. Laurie quoted a case in which the method of dilatation by tubes had been effective; in the particular instance tubes were passed on forty-five occasions. It was some years ago and the patient had remained well.

Mr. Kent Hughes in reply said that the injury resulting in stenosis was not always to be attributed to the tube; there might be extensive ulceration following the diphtheritic pro-

cess. With reference to the ultimate result he proposed to watch the progress in the larynx by means of the Killian-Lynch suspension apparatus, but he did not anticipate having to resort to dilatation.

In operating the surgeon should avoid cutting the vocal cords and it was advisable to use a relatively large tube to keep these structures well apart. In the case of the boy he had shown, he thought, that a good voice should be restored; repair of the vocal cords did occur, as he had observed, after the procedure of "punching" the cord.

Mr. Kent Hughes's second patient was a boy, aged 13, whom he had treated by Spengler's "*I.K.*" therapy for tubercular cystitis. The boy first came under treatment at the Children's Hospital in July, 1919. At that time he had half-hourly frequency of micturition. The urine contained much blood and pus; tubercle bacilli were also shown to be present. Treatment with "*I.K.*" (*Immunkörper*) was instituted and he had asked Dr. Webster to furnish him week by week with some quantitative guide to progress. Dr. Webster had suggested an enumeration of the red cells and pus cells in the twenty-four hour specimen of urine and had carried out these observations. During the period from July 14, 1919, to November 13, 1919, the pus cells declined from 12,000 per c.mm. to 5,400 per c.mm. and the red cells from 2,500 per c.mm. to 800 per c.mm.. The boy's general condition was very good; he had increased in weight and could retain urine for five hours.

Cytoscopic examinations had been carried out as follows:

On November 15, 1919, Mr. Balcombe Quick, D.S.O., had reported the presence of slight general congestion of the mucosa of the bladder; the internal urethral orifice contained translucent polypoid masses. The right ureteral orifice was slightly open with superficial ulceration of the margins. In the trigone were areas of ulceration and adherent lymph from the middle line to the left ureteral orifice, which was involved in a general ulcerative condition.

On January 8, 1920, Mr. Balcombe Quick had noted that there was no ulceration of the right ureter. This structure was patulous and was involved in a general inflammation of the trigone and of the area posterior to it. There was marked ulceration all round the orifice of the left ureter. Particles of lymph had been observed to have been extruded from it. In this trigone there was a mild inflammatory condition with superficial ulceration and scales of lymph.

On March 9, 1920, Dr. R. M. Downes, C.M.G., had reported that there was no ulceration of the right ureter. The left ureter was ulcerated. No particles of lymph were seen. The general condition of the bladder was apparently improved.

On May 15, 1920, Dr. R. M. Downes had found that the bladder capacity was 105 c.cm.. The right ureter was patulous and thickened, while the left ureter was clear. The ulceration, however, extended medially from the left ureter. Several tubercles were observed anteriorly to the left ureter. The inflammatory condition of the bladder was less marked.

Coincident with the cystoscopical examinations, a laboratory examination of the urine was carried out. On each occasion pus, blood and tubercle bacilli were found.

In the specimens of urine examined on September 30 and October 5, 1920, tubercle bacilli could not be demonstrated microscopically after prolonged search. The most recent cystoscopical examination was that of October 1, 1920. Dr. Downes had reported that the bladder capacity was 150 c.cm. and that there was a general improvement of moderate degree. The right ureter was patulous and the ulceration was situated to the dorsal side. Definite ulceration was seen in the left ureter, with small tubercles laterally.

Mr. Kent Hughes submitted that the boy had made considerable improvement, although the process in the bladder was not yet completely healed. Whereas throughout a long series of examinations for tubercle bacilli the findings had been positive without exception, in the last two searchings these organisms could not be detected.

In answer to questions, Mr. Kent Hughes stated that "*I.K.*" was a preparation of Carl Spengler, of Davos. Spengler had made observations which indicated that tuberculosis immune substances were manufactured and stored in the red blood cells and that relative to the serum they contained as much as 1,000,000 to 1 of these substances. "*I.K.*" (*Immunkörper*) was prepared from the blood of rabbits highly immunized against the tubercle bacillus. "*I.K. Original*" was to be used in what appeared to be extreme dilution for initiating treatment. Dilution I. was "*I.K. Original*" 1: 10; dilution II., 1: 100; dilution III., 1: 1,000 and so on to dilution VII., which was 1: 10,000,000. Treatment was generally commenced with 0.15 c.cm. of dilution VI. (1: 1,000,000), followed a week later by 0.3 c.cm.; seven days later by 0.6 c.cm.. The next dose would be 1.2 c.cm. or 0.12 c.cm. of dilution V.. The guide to dosage and frequency was the presence or absence of reactions in the patient. The treatment was carried out in very much the same manner as tuberculin therapy.

Dr. Wm. Dismore Upjohn, O.B.E., and Dr. H. Boyd Graham gave full details of three cases in which blood transfusion had been employed. The conditions for which it had been used were: (*i.*) Banti's disease, after splenectomy was performed, (*ii.*) profound anæmia associated with nasal diphtheria, (*iii.*) chronic osteomyelitis, with prolonged sepsis and amputation at the hip joint.

Dr. F. Kingsley Norris requested consideration for the case of a girl, aged 6½ years, with widespread glandular enlargement. The child's illness dated back to the early months of 1917. She attended the Children's Hospital at the end of August of that year, when she sought treatment for a "swelling behind the left ear." The left tonsil was noted to be somewhat enlarged and a mass composed of enlarged glands, not very tender and without fluctuation, was present in the left upper cervical region. The child was stated to have been deaf at times, but no history of discharge from the ear could be elicited. The girl was one of a large family, all of whom were healthy with the exception of one child, who was said to have "spinal trouble." One week after the child's first attendance at the hospital the glands were re-recorded as subsiding under applications of plastine. The result of the Wassermann test was noted as "feeble partial."

Eight months later the child reappeared in the out-patient clinic, exhibiting multiple discrete glands in the left side of the neck. A searching dental examination failed to disclose any septic process. An examination of a blood film also yielded no indication of a pathological process. On June 19, 1918, one of the affected glands was excised and Dr. Webster reported that he considered the condition to be lymphadenoma or Hodgkin's disease. In January, 1919, a second sample of blood was sent for the purpose of the Wassermann test; the report was "feeble partial."

The girl came under Dr. Norris's observation in May, 1919. At that time she was febrile and the leucocyte count was slightly raised (12,000 per c.mm.). The left cervical swelling was still very evident. By December, 1919, the glandular enlargement had involved both the triangles of the neck and glands were palpable in both axillæ and in the right groin. It was not possible to determine whether the spleen was definitely enlarged.

The child had been treated with potassium iodide and grey powder for the greater part of the two years of her attendance at the hospital. In December, 1919, Dr. Norris administered 0.2 grm. of salvarsan, followed after a fortnight's interval by a second dose of the same quantity. By the end of January, 1920, the cervical glands were smaller and softer, no axillary glands could be palpated and enlargement of the spleen could not be detected. There was, however, an enlarged gland of the size of a walnut in the right groin. X-ray treatment was commenced in February, 1920, and at fortnightly intervals the affected glands were given five minute exposures to full doses of the rays, filtered through aluminium. A remarkable degree of improvement had resulted, but Dr. Norris was disposed to think that it was merely a remission, as during the week or two preceding the meeting the spleen had become enlarged and was definitely palpable.

Mr. Kent Hughes commented on the indurated and "shotty" character of the still palpable glands and Dr. Norris added that X-ray examination of the thorax had not revealed any enlargement of the bronchial glands. The girl was now afebrile.

Dr. H. Douglas Stephens showed an infant, aged eight months, who had been sent to the hospital with the provisional diagnosis of intestinal obstruction (intussusception). Two days before admission the baby commenced vomiting and continued to reject every drink. No information could

be obtained from the mother regarding a screaming attack. Twenty-four hours prior to admission the child passed a normal motion; of two stools since that time, one was green and slimy and the second consisted of slime only, with no normal fæces. The child was breast fed. A diffuse bronchitis occasioned feverishness, grunting and rapid respirations.

When the baby was brought to the hospital the abdomen was observed to be full and irregularly distended. A globular tumour in the right kidney region was readily felt. It was freely movable and could be felt *per rectum* by bi-manual examination. An enema administered at this time resulted in a return of fæcal matter, unaccompanied by slime or blood.

An exploratory laparotomy was undertaken and the tumour, situated retro-peritoneally, was found to be a polycystic kidney. It was removed by the transperitoneal route and was seen to comprise one large cyst and three smaller cysts. The pathological report on the specimen was to the effect that the wall of the cyst consisted of fibrous tissue only with no parenchymatous elements. There was no indication of the origin of the cyst in the microscopical section. In the fluid contents were noted red blood cells and an excess of mononuclear leucocytes. No evidence of hydatid was detected.

Dr. Stephens commented on the very rare occurrence of a unilateral congenital cystic kidney. He had met with several such bilateral conditions, but had not hitherto encountered congenital cystic disease of the kidney limited to one side, nor had he been able to find in the literature a record of its unilateral occurrence.

With reference to cystic disease of the kidneys, Dr. F. T. A. Lovegrove detailed the case of a soldier who had been admitted to No. 11 Australian General Hospital for hæmatemesis on September 8, 1920. Slight attacks had been experienced in Egypt and at intervals since that time. It was thought probably that he was the subject of a gastric ulcer, but the hæmorrhage recurred in a very aggravated fashion and the man died as a direct result on October 4, 1920. At autopsy an enlarged spleen, cirrhotic liver and grossly cystic kidneys were the principal pathological lesions found.

Although it appeared very improbable that this man was congenitally affected with cystic disease of the kidneys, yet the condition was obviously of long standing and it seemed remarkable that he had been able to complete 4½ years' excellent service.

Dr. Reginald Webster demonstrated the following pathological specimens:—

(1) Greatly enlarged spleen, removed by Dr. Upjohn from the child he had shown during the evening. Dr. Webster drew attention to the irregularly distributed opacities in the capsule of the organ and its generally firm consistence. There were numerous infarcts which he considered were thrombotic in origin. He had been informed by Dr. Upjohn that the weight of the organ at the time of the operation was 750 grammes.

A microscopical slide of a section of the spleen was present for inspection. Regarding this preparation, apart from general increase in the supporting tissue, the most noticeable feature was a great increase in size and number of the sinuses, which imparted a much more open and reticulated structure than was seen in the normal spleen. There was some endothelial hyperplasia, but this was not comparable with that observed in the Gaucher type of splenomegaly.

(2) Pyloric hypertrophy, giving rise to a small tumour of the size of a walnut.

(3) Congenital tracheo-œsophageal fistula. The infant from whom this specimen was obtained was under the care of Dr. H. Douglas Stephens, who supplied an outline of the clinical details. Admitted to hospital at the age of four days, the baby was said not to have swallowed anything since birth. When a drink was given, it appeared to be held in the throat for a short interval and was then rejected. The infant was given a bismuth preparation by means of a pipette and by X-ray examination it was seen that the food did not pass beyond a point at the upper level of the *manubrium sterni*. Dr. Stephens performed the operation of gastrostomy and feeding through the opening led to coughing and the ejection of milk through the mouth and nostrils.

The specimen showed a dilated pouch at the upper end of the œsophagus, which pouch terminated blindly 2 cm. above the bifurcation of the trachea. Immediately below the lower extremity of this pouch, but not connected with it, the œsophageal tube was seen to be fused on to the trachea. From this point the œsophagus continued onwards and passed through its normal opening in the diaphragm. A glass rod, introduced through the glottis, could be passed at will into one or other bronchus, or into the œsophagus, through the stomach and out by the gastrostomy opening.

University Intelligence.

THE UNIVERSITY OF SYDNEY.

An adjourned meeting of the Senate of the University of Sydney was held on December 13, 1920. The following appointments were made:—

Chair of French: Professor G. G. Nicholson.
Chair of English Literature: Mr. J. de Gay Brereton.
Chair of Physiology: Professor H. G. Chapman.
Associate Chair of Physiology: Dr. Henry Priestley.
Chair of Dentistry: Dr. R. Fairfax Reading.

The applications for the Chair of French were considered by a Selection Committee in London, acting under the presidency of the Agent-General, and Mr. Nicholson was unanimously recommended as far and away the best candidate.

Mr. Brereton was also placed first by the London Committee on the list of candidates for the Chair of English Literature. The second name on the list was also that of a graduate of the University of Sydney.

In reference to the appointment of Professor Chapman as Professor of Physiology, who at present holds the position of Professor of Pharmacology, it was decided that the Chair of Pharmacology should not be filled up for the present and that the lectures in *materia medica* should be revived, the subject of pharmacology, which for many years was under the Chair of Physiology, returning to that Department. In connexion with the Chair of Physiology a separate committee in London also placed two graduates of the University of Sydney as their first and second choice for the Chair.

It was also decided not to call for applications at present for the Chair of Anatomy, Acting Professor Maguire being requested to continue to hold office for a further period of one year, with the assistance of Professor Sandes and Dr. S. A. Smith.

On the recommendation of the Professorial Board, it was resolved that the regulation allowing candidates who obtained the Leaving Certificate, but failed in one or other of the matriculation subjects, to complete their matriculation examination in March, be continued for this year, owing to the fact that the results of the Leaving Certificate Examination will not be available until February.

Regulations for the administration of the McCaughey Bequest Research Fund of £1,000 per annum were adopted as follows:—

(1) The McCaughey Research Fund shall be administered by a Standing Committee consisting of members of the Professorial Board.
(2) Any teacher or graduate of the University of Sydney shall be eligible to apply for a grant from the Fund, but unless the research is conducted within the University the applicant shall show to the satisfaction of the committee that he has at his disposal reasonable facilities for the prosecution of the proposed investigation. Applications shall be accompanied by a description of the research contemplated or in progress, and a statement as to the amount of the grant required. Upon completion of the research, a report shall be rendered to the committee by the applicant for transmission to the Senate, indicating precisely how the grant has been expended, and any unused balance shall be refunded. Whenever possible, such applications and reports shall be countersigned by the head of the department in which the research is conducted.

(3) Unless otherwise stipulated by the Committee, any books or permanent apparatus or equipment purchased by a grant from the fund shall be retained in the University upon the conclusion of the research.
(4) An acknowledge to the McCaughey Research Fund shall be made in any published record of work which has been aided by a grant from this Fund.

N.B.—(*a*) No rigidly defined allocations as between the several faculties or departments.
(*b*) As a matter of general policy the fund should be administered to meet the "running expenses" of investigations rather than to defray the cost of series of journals or permanent apparatus or equipment—at least a careful balance should be preserved between these two aspects of the expenditure, and in the later case inquiries should be made as to the possibility of meeting the expense from the maintenance vote of the library or the department concerned.
(*c*) The fund should not be utilized in founding or supplementing research scholarships or exhibitions, except by the special permission of the Senate.

In the faculty of Science an amendment was made in the By-laws relating to the Matriculation Examination for admission to that Faculty. On and after March, 1922, candidates will be required to pass in the following subjects at the higher standard in (1) English, (2) Latin, Greek, French or German, (3) mechanics or one of the following sciences: botany chemistry, geology, physics, physiology, zoology; they must also pass in mathematics, which may be at the higher or lower standard.

The annual report of the University Extension Board was received and the members of the Board were re-elected for a further term of one year.

The minutes of the first meeting of the Standing Advisory Committee of the Australian Universities were received. The meeting was held in Melbourne in the month of November, 1920.

Obituary.

GEORGE HUGH SPENCER BLACKBURNE.

In the afternoon of November 11, 1920, Dr. G. H. S. Blackburne was summoned from Albany to Denmark, to attend to a patient who had met with a serious accident. He travelled by a railway motor trolley, reached his destination safely, accomplished the object of his mission and started the homeward journey at shortly after ten o'clock in the evening. He was accompanied by a driver and a constable. When about two miles from Albany the trolley was directed into a siding until the line was cleared. Owing to a mistake in some shunting operations, two trucks were driven at a considerable speed on to the siding and collided with the motor trolley. George Hugh Spencer Blackburne and the constable were discovered lying unconscious beside the permanent way. The trolley driver was found lying across the trolley severely injured. He died an hour and a half later, while the doctor lived for nearly three hours. The constable was not seriously injured. The news of the death of George Hugh Spencer Blackburne was a great shock to his numerous friends and acquaintances throughout the State of Western Australia.

George Hugh Spencer Blackburne was born on October 30, 1874. He studied medicine at the Melbourne University, where he graduated in 1897. In the following year he came to Western Australia and shortly afterwards was appointed Resident Medical Officer at the Perth Public Hospital. He filled this position for two years. While at the Perth Public Hospital an epidemic of bubonic plague broke out and Blackburne was given the opportunity both of looking after the patients and of establishing the bacteriological diagnosis. He was permitted to erect an old tin shed on the Esplanade, which served as his laboratory. In 1901 he visited England, largely for the purpose of studying public health. He obtained the Diploma of Public Health at Cambridge. On his return to Perth he was appointed Acting President to the Central Board of Health, in which office he displayed marked technical and administrative ability. Later he was appointed bacteriologist and pathologist to the Department and performed his duties in a most admirable manner. In 1908 he resigned his departmental office and started practice at Albany. Public health work, however, still had a fascination for him; he sought and obtained the positions of quarantine officer, public vaccinator and district medical officer. In 1909 he obtained a commission in the Australian Army Medical Corps and subsequently he was appointed Medical Officer in command of the permanent troops at Albany. He was an able, conscientious, skilled practitioner and his patients held him in respect and affection. Although very reserved in manner, he enjoyed the confidence of a very large circle of friends and was very popular among his colleagues. He leaves a widow and six young children to mourn his loss.

THE ALVARENGA PRIZE OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

We are informed that the Alvarenga Prize for 1920 has not been awarded. The College of Physicians of Philadelphia announces that the next award will be made on July 14, 1921, provided that an essay deemed by the Committee to be worthy of the Prize, shall have been offered. The Prize is the income for one year of the bequest of the late Señor Alvarenga and is about $250. The essays may be on any subject in medicine. They must be type-written. An essay which has been published, cannot be submitted. Each essay must be plainly marked with a motto, without a signature. It must be accompanied by a sealed envelope, having marked on the outside the motto of the paper and within the name and address of the author. The essays must be received by the Secretary of the College, Dr. John H. Girvin, 19 South Twenty-second Street, Philadelphia, Pa., U.S.A., on or before May 1, 1921. Unsuccessful essays will be returned on application within three months of the award.

Correspondence.

DENTAL CARIES.

Sir: When reading the discussion of the Queensland Branch of the British Medical Association on dental matters, I thought the following facts might be of interest. They are based on observations made in a country practice during the past fifteen months:

(1) Aboriginal and half-caste children living on stations have almost invariably perfect teeth. The same class of children, when they live in Mitchell and have access to sweets and cake, suffer from dental caries. Neither country nor township children ever clean their teeth.

(2) Children who are allowed unlimited cakes and sweets, are often severe sufferers from caries, even though they clean their teeth.

(3) There has been an epidemic of lobar pneumonia in the district and all child patients have either grossly decayed teeth or diseased tonsils, more frequently the former.

(4) Great improvement has taken place in the health of children whose decayed teeth have been removed.

(5) In every case of a swollen face from a tooth abscess in which I have extracted the tooth, rapid recovery always followed.

My own deductions on the above facts are: (*a*) Sweet foods are the chief cause of decay. (*b*) Septic teeth in children should be removed. (*c*) Decayed teeth predispose to constitutional diseases.

Yours, etc.,
ELLEN M. KENT HUGHES.

Mitchell, Queensland,
December 7, 1920.

MOORFIELD'S OPHTHALMIC HOSPITAL, LONDON.

Sir: I have received a quantity of information from the Royal London Ophthalmic Hospital (Moorfield's), which is in desperate financial straits. The authorities are appealing throughout the civilized world for help from the very numerous specialists who have received their training in that efficient institution.

The staff of the hospital finds itself after the war, like so many other staffs, anxious to launch out in new directions,

chiefly pathological, but at the same time finds that the funds of the hospital do not enable it to carry on the necessary routine work.

I enclose for your information statements relative to its influence on the United States, on India and in Canada. Statements relating to its relation to Australia are to follow.

Specialists who respond to this appeal, can send their contributions to Mrs. Lang, 22 Cavendish Square, London; or, if they desire, to me. I shall be very glad to arrange for the transmission of their subscriptions to London.

Yours, etc.,

J. W. BARRETT.

105 Collins Street, Melbourne.
(Undated.)

Books Received.

MEDICAL ELECTRICITY: A Practical Handbook for Students and Practitioners, by H. Lewis Jones, M.A., M.D., F.R.C.P., Eighth Edition, Revised and Edited by Lullum Wood Bathurst, M.D.; 1920. London: H. K. Lewis & Co., Ltd.; Demy 8vo., pp. 575, with illustrations. Price, 22s. 6d. net.

INSTINCT AND THE UNCONSCIOUS: A Contribution to a Biological Theory of the Psycho-Neuroses, by W. H. R. Rivers, M.D., D.Sc., LL.D., F.R.S.; 1920. Cambridge: Syndics of the Cambridge University Press; Demy 8vo., pp. 252. Price, 16s. net.

It is with great pleasure that we have to announce that Sir Neville Howse, V.C., K.C.B., K.C.M.G., has been unanimously elected Mayor of Orange, New South Wales.

Medical Appointments.

The appointment as District Medical Officer and Public Vaccinator of Dr. W. F. S. Webb at Wickepin and of Dr. K. G. McKay Aberdeen (B.M.A.) at Northam, is announced in the *Government Gazette of Western Australia* of December 10, 1920.

From November 1, 1920, Dr. A. S. Johnson (B.M.A.) has been appointed Acting District Medical Officer and Public Vaccinator at Albany, Western Australia.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxvii.

Department of Public Instruction, Victoria: Two Medical Officers.

Commonwealth Public Service, Quarantine Branch, Brisbane: Medical Officer.

Royal Alexandra Hospital for Children, Sydney: Honorary Relieving Medical Officer.

Department of Public Works, New South Wales: Resident Medical Officer, Construction Camp.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C..

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA. (Hon Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

Dec. 30.—S. Aust. Branch, B.M.A..
Dec. 30.—Q. Branch, B.M.A., Council.
Jan. 4.—N.S.W. Branch, B.M.A., Council (Quarterly).
Jan. 11.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Jan. 12.—Northern District Med. Assoc. (N.S.W.), Narrabri (Annual).
Jan. 13.—Vic. Branch, B.M.A., Council.
Jan. 14.—S. Aust. Branch, Council.
Jan. 18.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Jan. 20.—Western Med. Assoc. (N.S.W.), Blayney.
Jan. 26.—Vic. Branch, B.M.A., Council.
Jan. 27.—S. Aust. Branch, B.M.A..
Jan. 27.—Q. Branch, B.M.A., Council.
Feb. 1.—Federal Committee of the B.M.A. in Australia.
Feb. 2.—Vic. Branch, B.M.A..
Feb. 4.—Q. Branch, B.M.A..
Feb. 8.—N.S.W. Branch, B.M.A., Ethics Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)

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